IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 14, 2007

Melissa Lichti, Administrator
Wedgewood Terrace, Provident Foundation
2114 Vineyard Ave
Lewiston, ID 83501

License #: RC-588

Dear Ms. Lichti:

On November 2, 2007, a state licensure survey was conducted at Wedgewood Terrace, Provident Foundation - Wedgewood Terrace LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Debby Sholley, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

Debbie Sholley, LSW

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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November 20, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0773

Melissa Lichti, Administrator
Wedgewood Terrace, Provident Foundation
2114 Vineyard Ave
Lewiston, ID 83501

Dear Ms. Lichti:

Based on the State Licensure survey conducted by our staff at Wedgewood Terrace, Provident Foundation - Wedgewood Terrace LLC on **November 2, 2007,** we have determined that the facility failed to protect residents from inadequate care. Based on observation, interview, and record review it was determined the facility retained 1 of 8 sampled residents (#5) for whom the facility did not have the capability, capacity and services to provide appropriate care. Retaining resident #5 had the potential to affect 100% of the other residents due to the infectious nature of the disease. The facility also did not update NSAs to describe how the residents' cares would be met for 3 of 8 sampled residents (#1, 2, & 8). The facility failed to implement an NSA for 1 of 8sampled residents (#5). Furthermore, the facility failed to assiste and monitor medications for 2 of 8 sampled residents (#3 & 8). Finally, the facility did not protect 2 of 8 sampled residents (#1 & 5) from neglect. Based on observation, interview and record review, it was determined that the facility failed to protect 2 of 8 (#1 & 5) sampled residents from neglect.

These core issue deficiencies substantially limit the capacity of Wedgewood Terrace, Provident Foundation - Wedgewood Terrace LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiencies are described on the enclosed Statement of Deficiencies.

Based on the seriousness of these deficiencies, the following enforcement action is imposed:

1. **A consultant with a background in residential care and an Idaho RN license will be obtained and paid for by the facility and approved by the Department. This consultant may not also be employed by the facility as a regular employee. The consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications and a copy of their license will be submitted to the Department for approval no later than Friday, November 30, *2007*;**

2. **The Department approved consultant will submit a weekly written report to the Department commencing on December 7, *2007* and every Friday thereafter. The reports will address progress on correcting the deficiencies on the statement of deficiencies and the non-core issue punch list.**

You have an opportunity to make corrections and thus avoid further enforcement action. Correction of these deficiencies must be achieved by **December 17, 2007. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **December 7, 2007,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**December 3, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **December 3, 2007,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **December 2, 2007.**

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Wedgewood Terrace, Provident Foundation - Wedgewood Terrace LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Program Supervisor
Residential Community Care

JS/sc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R588	A. BUILDING _____ B. WING _____	11/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEDGEWOOD TERRACE, PROVIDENT FOUNI	2114 VINEYARD AVE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiencies were cited during the standard health care survey conducted at your residential care/assisted living facility. The surveyors conducting your health care survey were: Debbie Sholley, LSW Team Coordinator Health Facility Surveyor Donna Henscheid, LSW Health Facility Surveyor Karen McDannel, RN Health Facility Surveyor Survey Definitions: ADA = American Dietetic Association ADL = activity of daily living BID = twice daily BM = bowel movement CNA = certified nursing assistant CVA = cerebral vascular accident EFC = extended care facility mEq = milliequivalent NSA = Negotiated Service Agreement PO = by mouth PRN = as needed pt. = patient RN = registered nurse TID = three times daily UAI = Uniform Assessment Instrument UTI = urinary tract infection	R 000	RECEIVED DEC 07 2007 FACILITY STANDARDS	
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all	R 008	**16.03.22.05.b.xi: Protect Residents from Inadequate Care.** The administrator will assure that policies and procedures are implemented to assure that all residents are free from inadequate care.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/6/07

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R 008	Continued From page 1 residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview, and record review it was determined the facility retained 1 of 8 sampled residents (#5) for whom the facility did not have the capability, capacity and services to provide appropriate care. Retaining Resident #5 had the potential to affect 100% of the other residents due to the infectious nature of the disease. The facility also did not update NSAs to describe how the residents cares would be met for 3 of 8 sampled residents (#1, 2, & 8). The facility failed to implement an NSA for 1 of 8 sampled residents (#5). Furthermore, the facility failed to assist and monitor medications for 2 of 8 sampled residents (#3 & 8). Finally, the facility did not protect 2 of 8 sampled residents (#1 & 5) from neglect. The findings include: I. Retaining a Resident Above Level of Care 1. Resident #5 was admitted to the facility on 10/18/05, with diagnoses which included vascular dementia, hypertension, cerebral vascular accident, diabetes mellitus, osteoporosis and hyperlipidemia. Resident #5's record contained a Laboratory Outpatient Report dated 5/11/07, which documented the resident was diagnosed with moderate to heavy growth active MRSA (Methicillin Resistant Staphaccous Aureus which is a staph bacterial infection and cannot be treated with the antibiotic methicillin.) The resident's Laboratory Outpatient Report also documented the facility's licensed nurse was notified about the active MRSA culture results on	R 008	No resident will be admitted or retained with active Mrsa. Staff will be trained upon hire thru the facilities 16 hrs. of Orientation training and annually there after. RN in place at time of inspection is no longer employed at Wedgewood Terrace. Nursing staff has been expanded to include 1 ft RN, 1ft LPN, 1pt LPN with 7 day a week coverage. In addition, a highly qualified Gerontological nurse has been retained in a consultant role. Resident #8 no longer resides at Wedgewood Terrace. All residents who experience a significant change in condition will be reassessed @ the time change is determined to be permanent & significant. A new NSA will be implemented, policy & procedures implemented regarding the change of condition.	10/31/07 12/17/07 12/17

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R 008	Continued From page 2 5/11/07 at 11:00 a.m. IDAPA 16.03.22.05.b.xi states that no resident be admitted or retained who has active MRSA. The facility retained Resident #5 after the resident was diagnosed in May 2007 with active MRSA. The facility did not have the capability, capacity and services to provide appropriate care to Resident #5 or to ensure 100% of the other residents were protected from acquiring the infectious disease. II. NSAs A. Updating of NSAs 1. Resident #8 was admitted to the facility on 8/30/06 with diagnoses which included dementia, CVA, IDDM (insulin dependant diabetes mellitus), history of blood clots and arterial fibrillation. The NSA was updated on 8/10/07 and documented the resident was independent with ADL's, mobile with the use of a walker or a wheelchair. The section under "Treatments" documented the resident was able to draw up and administer her own insulin and eye drops. The section under "Mental/Behavioral" documented the resident had increased confusion, and needed frequent reminders of when she "took her meds." Review of the Monthly Nursing Health Assessment dated 10/18/07 at 11:00 a.m., documented the resident required assistance with medications, but was safe to administer and keep her glucose tablets, inhaler and eye drops in a secure storage area in her room. Additionally, the assessment documented the resident had been complaining of shortness of breath, had edema	R 008	NSA Resident #8 no longer resides at Wedgewood Terrace Any resident being admitted with a Dr.'s order stating they may self medicate, will be assessed by facility nurse upon admission and monthly there after, upon a significant change in condition.	12/17

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R 008	Continued From page 3 from her knees to her feet. Further, the assessment documented the resident's feet were "very swollen" and the resident was forgetful at times. The Resident Progress Notes were reviewed and documented the following: On 10/18/07 at 11:00 p.m., "Increased edema 4 + pitting from knees to foot...more tired than usual..." On 10/28/07 at 12:00 p.m., "Resident has small blisters on bottom calf put bag balm on them to relieve itching will continue to monitor." On 10/30/07 at 9:00 p.m., "Resident's lower left leg red, warm and open blisters..." On 10/30/07 at 11:00 p.m., "Resident's lower calf very red with blisters at resident's request put bag balm on blisters. Legs and feet very dry unable to reach." On 10/31/07 during the 6:00 a.m. to 2:00 p.m., shift "Culture from leg wound obtained per orders - on left shin, yellow drainage noted in 4-6 spots the size of eraser heads on a pencil (less than 1 cm) centimeter." On 10/31/07 at 9:45 a.m., Resident #8 was observed in her room sitting in her recliner. Upon observation, her legs and ankles were red, swollen and very dry. Both lower legs had open draining blisters that were not covered by a dressing. On 11/1/07 at 12:45 p.m., the resident was observed in the main dining room, sitting in her wheelchair with a blanket draped over her legs.	R 008		

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R 008	Continued From page 4 There was no noted dressing to either lower leg to cover the open draining wounds. On 11/1/07 at 1:00 p.m., a caregiver was observed pushing Resident #8's wheelchair from the dining room to the resident's room. The caregiver stated the resident was not able to self-propel her wheelchair and relied on caregivers for mobility when using her wheelchair. The resident's room had clutter strewn about the floor, piles of papers stacked on chairs and tables; an inhaler, prescription eye drops and glucose tablets were left unsecured on the bedside table. The resident's bathroom had laundry soap, bleach and other cleaning supplies that were stacked under the sink counter top and were not kept in a secured area. On 11/1/07 at 1:05 p.m., the resident stated she would like to have some additional help from caregivers to help apply lotion to her lower legs, ankles and feet as these areas were hard for her to reach. She further stated she was no longer able to do her own laundry, and acknowledged her room could use some cleaning. Additionally, she stated her vision had declined since admission and she was no longer able to see well enough to dial the correct dose of insulin but was comfortable with injecting the medication. On 11/1/07 at 2:30 p.m., the administrator was informed of the resident's increased ADL needs. The administrator observed the resident's room and confirmed the cleaning supplies and medications should be stored in a secured area. She further stated she would inform the caregivers of the resident's need for assistance to apply lotion to her lower extremities, as well as, get a staff member to come clean and tidy up her room.	R 008	Infection Control Infection Control policies & procedures will be followed. All staff will be trained upon hire thru Orientation training and annually on Infection Control procedures. Staff has been in serviced and will continue to be trained annually. Any open wound will be reported to the licensed nurse per significant changes in policies & procedures. All open wounds will be reported to attending physician, covered to contain drainage, cultured as ordered and treated including outside referrals as appropriate. All residents with open wounds will have their NSA's updated to include current skin status and interventions to effect resolution.	12/3 12/4

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R 008	Continued From page 5 The NSA was not updated to describe Resident #8's current needs regarding activities of daily living. For example, increased mobility needs when using her wheelchair. Increased skin care needs due to the severe swelling in her lower legs and feet. The need for caregivers to ensure the resident was changing positions throughout the day and elevating her legs and feet. The NSA also was not updated to reflect the resident's decline in vision and inability to safely and accurately dial her insulin pen to the correct dose. 2. Resident #1 was admitted to the facility on 2/20/06 with diagnosis which included dementia, cerebral vascular accident, hypertension and ischemic heart disease. The resident was hospitalized from 9/5/07 to 9/10/07 and returned to the facility. On 9/19/07 the resident was admitted to hospice for failure to thrive related to underlying dementia. A hospice "Initial Home Visit" report dated 9/19/07 documented Resident #1 was confined to bed and had very limited mobility. It documented the resident, "Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Skin condition is excoriated (reddened/chapped). Moderate and severe excoriation on the groin area, it extends to perineum. Area is red, bright colored. Patient has moderate burning sensation in the area. Skin disorder occurred gradually and is related to urine incontinence and diarrhea. Overall ADL function is dependent. Physician ordered safety measures	R 008	Resident #1 no longer resides at Wedgewood Terrace.	

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R 008	Continued From page 6 to include: frequent turnings and 24 hour supervision." Resident #1's NSA dated 8/20/07 documented the resident used a walker and gait belt for unsteady gait, required assistance with walking at all times and needed hands on assistance with dressing. The resident also needed extensive assistance with toileting and reminders to use the restroom. Required extensive assistance twice a week with bathing and required hands on assistance to wash all areas. Resident #1's NSA was updated on 10/31/07 and included the following updates: Change and turn every 2 hours, full assist to ambulate, full assist with ADLs, pericare every shift, check for incontinence of BM every 2 hours and empty Foley catheter every shift. Provide bed bath or shower with full assist and change coccyx dressing every 5 days and PRN if the dressing falls off. On 10/31/07 at 3:00 p.m., Geri mits were observed on Resident #1's bedside table. A caregiver stated Geri mits were ordered because the resident scratched and dug at her bottom. The caregiver stated the mits had only been in the resident's room for one day and had not been used yet because the "resident had not been scratching today." Further, the caregiver stated a pillow was used to raise the resident's heels off the bed. On 11/1/07 at 11:00 a.m., staff members were observed transferring the resident from her bed to a wheelchair. It took 2 to 3 staff members and extensive direction from the RN to complete the transfer into the wheelchair. No cushion was observed to be in the resident's wheelchair and	R 008		

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R 008	Continued From page 7 the resident had pressure ulcers on her coccyx. Once positioned in the wheelchair, the staff were unable to stand the resident back up to put a pillow on the seat. On 11/1/07 at 11:50 a.m., a caregiver stated Resident #1 had been in bed for at least 2 months and had been on a turn schedule since approximately the beginning of October. The caregiver also stated the resident could be turned with only one assist but "two was more comfortable." Further, the caregiver stated, "I was not aware of the need to get resident up from the bed." The caregiver stated that hospice talks to the medication aides and the nurse about the resident care needs and that information is passed onto the rest of the staff. On 10/31/07 at 4:05 p.m., the administrator stated Resident #1 had started staying in bed since August because the resident's health had been declining and the resident had not been eating. On 11/1/07 at 12:40 p.m., the hospice RN stated a 2 hour turning schedule had been initiated since the first day of service on 9/19/07 but she could not say if it was or was not being done. Resident #1 had a significant change of condition following a hospitalization in September. The resident's NSA was not updated until 10/31/07. For approximately two months, the staff provided cares without specific direction being outlined on the NSA. Further, the updated NSA did not accurately reflect the resident care needs. The updated NSA did not include what services were being provided by the outside hospice agency regarding catheter cares, bathing and wound dressings. The updated NSA did not include the	R 008	Care staff has been in serviced on transfers, repositioning, and catheter care. Training will occur annually. All residents will be assessed upon move in, change of condition quarterly by RN. If resident is determined to be at risk for skin breakdown, will have individualized interventions, including pressure reducing devices added to NSA with the goal of preventing breakdown. All outside providers (Home Health, Hospice, PT, OT & Speech) will be requested to provide a copy of their plan of care to Wedgewood Terrace so that all staff are aware of interventions. All resident who experience a significant change in condition will be reassessed @ the time of identification. If the change is determined to be permanent & or significant an updated NSA will be implemented.	12/3 12/4 12/17 12/17

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R 008	Continued From page 8 use of the Geri mits for the resident's "digging" behaviors, nor did the NSA include direction to staff regarding skin precautions such as floating the resident's heels and turning schedule. Further, the updated NSA did not provide direction to staff regarding the number of staff required for turning, lifting and transferring. 3. Resident #2 was admitted to the facility on 3/17/05 with diagnoses which included dementia, diabetes, Parkinson's Disease and prostate cancer. Resident #2's NSA dated 5/5/07 documented the resident required a 1500 ADA diet and reminders to go to the dining room for meals. Under the section "General Medical Needs" it documented the resident required diabetic monitoring and accuchecks before meals. No other medical needs were documented. A dysphagia evaluation dated 5/29/07 documented Resident #2's diet was changed to pureed solids with thin liquids. A fax sent to Resident #2's physician dated 10/18/07, documented the resident had 2+ pitting edema. The physician instructions to staff were to "elevate legs." The October 2007 MAR documented the resident's legs were to be elevated for 2 hours a day. From 10/31/07 through 11/02/07, the resident was not observed to have legs elevated. Resident #2's NSA was not updated to reflect the change made to the resident's diet six months earlier nor did the NSA provide direction to the staff regarding the resident's edema identified in and need to elevate his legs.	R 008	Resident #2 no longer resides @ this facility.	

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R 008	Continued From page 9 B. Implementation of the NSA 1. Resident #5 was admitted to the facility on 10/18/05, with diagnoses which included vascular dementia, hypertension, cerebral vascular accident, diabetes mellitus, osteoporosis and hyperlipidemia. The NSA was updated on 4/12/07, and documented the resident required total assistance with mobility and transferring and staff were to, "use gait belt" with all transfers. On 10/31/07 at 10:30 a.m., a caregiver was observed transferring Resident #5 from her recliner back to her bed. The caregiver did not use a gait belt to transfer the resident. On 10/31/07 at 12:15 p.m., a caregiver was observed transferring the resident from her bed to her wheelchair. The caregiver did not use a gait belt to transfer the resident. On 10/31/07 at 12:20 p.m., 2 random caregivers stated they had never used a gait belt to transfer Resident #5. One of the caregivers stated, "Most of us can transfer her on our own. But, there are a few aides who need help and they just call one of us when she needs to be transferred." On 10/31/07 at 2:50 p.m., the licensed nurse stated, "I've only been here about 1 month and I honestly don't know if (Resident #5) needs a gait belt for transfers. I don't think staff are using a gait belt when they transfer her." The facility failed to implement Resident #5's NSA when they did not use the gait belt to transfer her.	R 008	All residents who experience a significant change in condition will be reassessed @ the time of identification. If the change is determined to be permanent & or significant an updated NSA will be implemented by the licensed nurse. All Licensed Nurse's will be familiar with interventions on NSA. Resident # 5 no longer resides at Wedgewood Terrace.	12/17

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	13R588	A. BUILDING _____ B. WING _____	11/02/2007

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R 008	Continued From page 10 III. Assistance and Monitoring of Medications 1. Resident #8 was admitted to the facility on 8/30/06, with diagnoses which included dementia, cerebral vascular accident, insulin dependant diabetes mellitus, glaucoma and a history of blood clots. Review of the facility's October 2007 MAR, documented the resident was given "KDur 10 meq 2 tablets by mouth every morning." Additionally, the MAR documented the resident used an insulin pen "Humalog inject subcutaneously as directed per physician's sliding scale orders (4 units with meals)." Resident #8's physician's orders dated 10/25/07, documented to increase the resident's potassium "KDur 20 meq (milliequivalent) 1 tablet three times per day and KDur 10 meq 1 tablet at night." On 11/1/07 at 5:15 p.m., observations were made of the medication aide assisting Resident #8 with her evening medications. The medication aide dialed the insulin pen to 4 units and handed it to the resident. The resident set the insulin pen down on the table next to her recliner. The medication aide then assisted the resident with her other evening medications. "KDur 10 meq" was not given to the resident. After the resident finished swallowing her medications the caregiver was observed to attempt to leave the resident's room without observing the resident injecting her insulin. The medication aide stated, "I dial the dose units of insulin due to the resident's inability to see well enough to dial her insulin pen; then I hand the resident the insulin pen and she decides when she wants to inject the insulin. Many times she waits until she is alone in her room to inject	R 008	Resident #8 no longer resides at Wedgewood Terrace Med Tech staff re-trained on the 7 rights of medication assistance. All medication variances will be documented as an incident (med errors) and investigated as per facility policies. It is the policy & practice of Wedgewood Terrace to respect the rights of residents to have privacy & choices in the self-direction of these cares.	12/7

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R 008	Continued From page 11 her insulin." On 11/1/07 at 5:20 p.m., observation of Resident #8's blister pack label and the medication inside the package revealed the resident had been receiving "KDur 20 meq 2 tablets by mouth every morning." The facility nurse stated she was not aware of the drug dose change and confirmed the resident had gone 8 days without the correct dose of KDur. On 11/1/07 at 5:30 p.m., the administrator and facility nurse were informed of the medication aides dialing the dose of insulin for Resident #8 and leaving without observing if the resident had injected her insulin. The administrator and nurse confirmed they were not aware that the medication aides were dialing the insulin dose and had not been observing the resident injecting herself. They were informed of the medication discrepancy concerning the KDur (potassium) order on 10/25/07, and that the resident had gone 8 days without the proper dose of KDur. 2. Resident #3's record revealed the resident was admitted on 7/12/07, with diagnosis of hypertension and a previous cerebral vascular accident. Resident #3's NSA dated 7/12/07, documented the resident was independent with taking her medications. On 11/1/07 at 11:15 a.m., during an interview with Resident #3 she stated she had been to her physician on 10/31/07, and was prescribed a new medication. The resident stated, "I took the medication but I don't remember why the physician ordered it, or the purpose of the medication. The medication aide was not familiar	R 008	Licensed nurses will retrain and reinforce the medication policy with med techs and will review annually or as needed. On initial assessment of resident the facility nurse will discuss the medication policy with the resident and or family members. All new orders and medication changes will be reviewed, signed off and noted by licensed nurse. Resident #3 has been reassessed, to determine ability to self-medicate.	12/2 12/17

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R 008	Continued From page 12 with the medication, but told me to take it and she would come back later and let me know the purpose of the new medication." On 11/1/07 at 11:17 a.m., the facility nurse was informed of the medication aide assisting the resident with a new medication order and the lack of understanding the resident and the medication aide had regarding the new medication. The nurse confirmed that the medication aide was practicing out of the scope of her job, training and level of education. Unlicensed staff were administering medication without a nursing license. Resident #8 was unable to dial the prescribed dose of insulin and the medication aides were dialing the insulin dose for the resident. Further there was a medication discrepancy for Resident #8 concerning the KDur (potassium) order on 10/25/07, the facility nurse was not aware of the order change resulting in the resident going without the proper dose for 8 days. Additionally, Resident #3 had questions and concerns regarding a new medication, these questions required the knowledge of a licensed nurse. The medication aide had not informed the facility nurse of the resident's questions. Instead the medication aide attempted to educate the resident without proper knowledge or understanding of the medication.	R 008	All residents are to be assessed by RN. Residents having difficultly dialing insulin pens will be offered alternatives & adaptive equipment, including but not limited to: Diabetic nurse education referral Magnifying devices Pre filled syringes Residents identified as having educational needs regarding treatments & medications will have training provided by License Nurse.	1213
R 009	16.03.22.525 Protect Residents from Neglect. The administrator must assure that policies and procedures are implemented to assure that all residents are free from neglect. This Rule is not met as evidenced by: Based on observation, interview and record	R 009	**16.03.22.525: Protect Residents from Neglect.** The administrator will assure that policies & procedures are implemented to assure that all residents are free from neglect with the assistance of the licensed nurses.	

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R 009	Continued From page 13 review, it was determined that the facility failed to protect 2 of 8 (#1and #5) sampled residents from neglect. The findings include: 1. Resident #1 was re-admitted to the facility on 9/10/07 following a hospitalization for dehydration. The resident's diagnoses included: CVA, ischemic heart disease, failure to thrive related to underlying diagnosis of dementia and stage II pressure ulcers. A. BED MOBILITY,TRANSFERS AND REPOSITIONING Resident #1's progress notes dated 9/18/7 documented the resident had "about 5 blister/sores. Calazyme cream applied and Diflucan to begin in the evening." A hospice "Initial Home Visit" report dated 9/19/07 documented Resident #1 was confined to bed and had very limited mobility. It documented the resident, "Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Skin condition is excoriated. Moderate and severe excoriation on the groin area, it extends to perineum. Area is red, bright colored. Patient has moderate burning sensation in the area. Skin disorder occurred gradually and is related to urine incontinence and diarrhea. Overall ADL function is dependent. Physician ordered safety measures to include: frequent turnings and 24 hour supervision." A "Hospice Plan of Treatment" form dated	R 009	Resident #1 & #5 no longer resides at Wedgewood Terrace. Care staff in serviced on the importance of adequate documentation. Licensed nurses to monitor on a weekly basis to ensure that the deficient practice does not re occur.	12/3 12/4

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R 009	Continued From page 14 9/19/07 documented the resident had "significant excoriation to her perineum, probably due to incontinence of urine and recent problems with diarrhea." Hospice notes dated 9/29/07 documented "reviewed positioning, skin care with caregiver, ...skin condition excoriated." The "Resident Check" list for September 2007 documented Resident #1 was to be checked 4 times per shift, 12 times per day and more if needed. The resident did not receive checks on these dates: *First Shift - 3, 4, 12, 13, 14, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30 which would have been 72 position changes. *Second Shift - 3, 4, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29 and 30 which would have been 80 position changes. *Third Shift - 4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, 25, 26, 27, 28, 29 and 30 which would have been 84 position changes. Hospice notes dated 10/4/07 documented the resident required "frequent turnings and 24 hour supervision" for safety. Hospice notes dated 10/18/07 documented Resident #1's skin condition was "excoriated, broken, clean and flaky. The notes also documented the resident's physician was contacted and new wound care orders were received for the resident's stage II pressure ulcers. The resident had a Stage II pressure ulcer on her coccyx which measured 0.5 cm x 1 cm and a Stage II pressure ulcer on the right buttock	R 009	Care staff have been in serviced on proper documentation of care provided, transfers, positioning and catheter care. Training will occur annually. All residents will be assessed upon move-in and when change of condition occurs & quarterly by RN. If resident is determined to be @ risk for skin breakdown will have individualized interventions including pressure reducing devices added to NSA with the goal of preventing skin breakdown.	12/3 12/4

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R 009	Continued From page 15 area which measured 0.2 cm x 0.3 cm. Resident #1's skin was assessed, "entire area was excoriated and the residents heels were red and "felt mushy". Hospice notes dated 10/18/07 documented the hospice RN was asked by a facility caregiver when staff could get the resident up out of bed again. It was further documented, "She [facility aid] tells me she is not sure why they stopped (getting the resident up) and was wondering if it is because the pt. is now on hospice." The hospice RN spoke with the administrator and was told there was no reason the resident could not get out of bed. The hospice RN notified the staff of the conversation with the administrator and also instructed staff on the need to turn the resident every 2 hours. Further, the hospice RN informed the physicians's office "the resident's care may exceed the level at [facility's name] and pt. may need to be transferred to a nursing home." Hospice notes dated 10/23/07 documented the hospice RN discussed the resident's care needs with the facility RN. The facility RN stated the staff would be encouraged to turn the resident every 2 hours but they would "not likely get her up in chair as total lift and no cardiac chair available." The hospice nurse stated the resident would "not likely tolerate getting up out of bed. Will give it a couple more weeks at [facility's name]. If skin condition further deteriorates, will likely request family transfer pt. to ECF." The "Resident Check" list for October 2007 documented Resident #1 did not receive checks on theses days: *First shift - 2, 3, 8, and 15 which was 16 position changes.	R 009		

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R 009	Continued From page 16 *Second shift - 1, 2, 7, 8, 9, 10, 15, and 18 which was 32 position changes. *Third shift - 9, 10, and 28 which was 12 position changes. On 10/31/07 at 4:05 p.m., the administrator stated Resident #1 had started staying in bed since August because the resident's health had been declining and the resident had not been eating. On 11/1/07 at 11:15 a.m., the administrator stated Resident #1 was no longer walking with her walker and was in the wheelchair only as needed. The administrator stated it was the RN's decision to go with hospice after the resident came back from the hospital and they had not discussed obtaining home health for therapy services. On 11/1/07 at 10:20 a.m., a family member stated Resident #1 had been in the hospital for 3 or 4 days the first part of September. "When [Resident's name] returned to [facility's name] they put her to bed and let her lay there. She got real weak." On 11/1/07 at 10:45 a.m., a family member stated the resident was sent to the hospital for dehydration on September 5th and returned to the facility on September 10th and had been in bed since that time. The family member stated she had not seen staff get the resident out of bed since the beginning of September. On 11/1/07 at 11:00 a.m., the facility RN stated the resident had been on bedrest since she started work at the facility, one month ago. The	R 009		

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R 009	Continued From page 17 facility RN also stated staff did 2 hour turns and documented this on the "Resident Check List" which was hanging on the resident's door. The RN stated hospice was told "if the resident needs a Hoyer lift and they won't provide one, then the resident would have to go to another place. We don't get her up because it's a safety issue." On 11/1/07 at 11:05 a.m., a caregiver stated, "I didn't know how long the resident had been in bed but at least two months. We used to walk her with a walker but because she tried to get up on her own, she was discouraged from walking." On 11/01/07 at 12:20 p.m., a hospice CNA stated she had been going to the facility for a little less than a month and had not seen the resident out of bed. The CNA stated that on two separate occasions (unsure of the dates) the resident was found laying in feces and on the second occasion, the hospice staff had also found "bed sores." On 11/1/07 at 12:40 p.m., the hospice RN stated a 2 hour turning schedule had been initiated since the first day of service on 9/19/07. Further, the hospice RN stated the director of the hospice agency spoke with the administrator approximately one week ago about concerns regarding the resident's care and stated, "there have been some improvements since then." The facility failed to protect Resident #1 from neglect by not providing, monitoring or offering assistance with bed mobility, transfers or repositioning. Resident #1 was confined to bed for approximately two months and did not receive assistance to transfer out of the bed nor did the resident receive adequate repositioning which contributed to skin breakdown.	R 009	All out side providers (HH, Hospice, PT, OT) will be requested to provide Wedgewood Terrace a copy of plan of care to foster communication & continuity of care for the resident. Licensed nurses to monitor.	12/17

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R 009	Continued From page 18 BATHING Resident #1's ADL log dated August 2007 documented the resident received a shower on August 4, 7, 16, 20 and 23. Resident #1's ADL log dated September 2007 did not include documentation a shower had been provided for the entire month of September. Hospice notes dated 9/26/07 documented the resident was given a bed bath by hospice staff. Hospice notes dated 9/29/07 documented the hospice RN, "reviewed positioning, skin care with caregiver, wash hair with bed bath." The facility shower schedule for September 2007 documented Resident #1 received bedding changes on September 5th and the 18th and received a shower from facility staff on the 29th. There was no documented evidence the resident had received a shower or bed bath from August 23rd to September 29th, a total of 34 days. On 11/1/07 at 10:15 a.m., a family member stated that "about 1 1/2 weeks ago the hospice staff alerted me they had found [Resident's name] with BM on her hands. I thought it was old fingernail polish." On 11/1/06 at 10:30 a.m., another family member stated the family had concerns with Resident #1's hygiene, especially with the frequency the resident was getting showers and having hair washed. The family member also stated the hospice staff had informed the family of finding the resident laying in feces on two occasions.	R 009	Resident #1 no longer resides at Wedgewood Terrace.	

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R 009	Continued From page 19 On 11/1/07 at 11:20 a.m., the administrator stated the resident "may have been given a bed bath but staff didn't document it." On 11/01/07 at 12:20 p.m., a hospice CNA stated that on two separate occasions (unsure of the dates) Resident #1 was found laying in feces. The resident had dried feces on her buttocks, hands and under her fingernails. "You could tell she had been laying in it a long time because it was very dried." The CNA also stated "about a week ago the resident's bedding was found dirty and the resident's hair was very matted and full of knots. "Our hospice director talked to their director and this week has been the best week in regards to [resident's name] care we have seen." The facility failed to protect Resident #1 from neglect by not providing showers or bed baths to ensure the resident's hygiene needs were being met. There was no evidence the resident received a shower or bed bath for 34 days. 2. Resident #5 was admitted to the facility on 10/18/05, with diagnoses which included vascular dementia, hypertension, cerebral vascular accident, Diabetes Mellitus, Osteoporosis and Hyperlipidemia. Resident #5's record contained a Laboratory Outpatient Report dated 5/14/07, which documented that on 5/11/07 the resident was diagnosed with moderate to heavy growth active MRSA (Methicillin Resistant Staphylococcus Aureus). The resident's Laboratory Outpatient Report also documented the laboratory staff called the facility's licensed nurse on 5/11/07 at 11:00 a.m., and informed her about Resident #5's active	R 009	Care staff have been inserviced on transfers, positioning and catheter care, and bathing. Training will occur on annually. All residents will be assessed upon move-in and when change of condition occurs & quarterly by RN. Licensed nurses to monitor for compliance. Care staff to be in serviced on the importance of documentation of care given to residents (i.e. bed bath, showers, etc.). Resident #5 no longer resides at Wedgewood Terrace	12/3 12/4 12/3

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R 009	Continued From page 20 MRSA culture results. There was no further documentation in Resident #5's record regarding follow up appointments with the physician, or laboratory reports that indicated the facility had requested the resident be re-cultured to verify if the MRSA was still active or if the antibiotic had been effective. On 10/31/07 at 2:28 p.m. the licensed nurse and the administrator confirmed the last culture that was done was on 5/11/07. Additionally, the licensed nurse stated, "I contacted the resident's physician a few weeks ago because (Resident #5) was out of her antibiotic and she continued to have green drainage from her eyes." The licensed nurse provided a copy of a note dated 10/31/07 that she had faxed to the resident's physician the day of the survey that documented, "Resident has had no results of clearing up green drainage in eyes that has continued for several months. Currently on Gentamicin with no results. Last culture in May said she had MRSA. Would you like another culture done?" On 10/31/07 at 2:48 p.m., the licensed nurse and the administrator confirmed that even though the resident continued to have green drainage from her eyes, the last time the resident was cultured for active MRSA was 5 months ago. The facility failed to protect Resident #5 from neglect when they did not ensure the resident's MRSA was no longer in an active stage. Additionally, the facility failed to protect Resident #1 from neglect by not providing, monitoring or offering assistance with bed mobility, transfers or repositioning. Further, the facility did not provide showers or bed baths to ensure the resident's hygiene needs were being met. These failures	R 009	No resident will be admitted or retained with active Mrsa.	10/31

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R 009	Continued From page 21 resulted in neglect. The facility retained Residents #5 who had MRSA, however, they did not have the capability, capacity and services to provide appropriate care. By retaining Resident #5, 100% of the other residents were potentially affected due to the infectious nature of the disease. The facility also did not update Residents #1, 2 & 8's NSAs to describe how their care needs would be met. The facility failed to implement Resident #5's NSA. Furthermore, the facility failed to assist and monitor Resident #3 & 8's medications. Finally, the facility did not protect Resident #1 & 5 from neglect.	R 009	Staff will be trained upon hire thru the facility 16 hrs. orientation training program and annually there after. Corrective actions will be monitored by no admission or retaining any potential resident with active Mrsa.	12/17 10/31

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

I

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Wedge Wood Terrace	2114 Vineyard Ave	(208) 743-2268
Administrator	**City**	**ZIP Code**
Melissa Lichti	Lewiston	83501
Survey Team Leader	**Survey Type**	**Survey Date**
Debbie Shelley	Standard	11/2/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	250.09	The facility did not take preventative measures to prevent offensive odors i.e. stale urine odor through out facility, especially the locked unit.		
2	260.06	The facility did not maintain the interior of the facility in a clean, safe and orderly manner i.e. dusty, spotted carpeting and RM 211.		
3	300.01	Nursing assessments over due for Resident 1, 2, 3, 4, 5, 6 & 7.		
4	300.02	The RN did not review and implement new orders for Residents #4 + #8.		
5	305.01	The RN did not assess bedrail use for Resident #1 and random residents in rooms 209 and 363. The RN did not assess Resident #85 use of a heating pad.		
6	305.06	The RN did not reassess Resident 3+4's ability to continue to self-medicate.		

Response Required Date	Signature of Facility Representative	Date Signed
12/2/07	Melissa Lich.	11/2/07

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(II)

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Wedge Wood Terrace	2114 Vineyard Ave	(208) 743-2268
Administrator	**City**	**ZIP Code**
Melissa Lichti	Lewiston	83501
Survey Team Leader	**Survey Type**	**Survey Date**
Debbie Sholley	Standard	11/2/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
~~6~~	~~305.02~~	error KM		
7	305.08	The facility RN did not provide staff education re: basic ADL'S, transferring, bathing, needs for increased resident needs to assist with mobility, infection control precautions re: MRSA & catheter care.		
8	310.01	The facility maintained multiple over the counter, prescription medications in bulk containers without a variance from the department of licensing & certification.		
9	310.01.a	Residents #3, 4 & 8's medications were not kept in a locked area.		
10	320.03	Not all residents NSA's were signed & dated by appropriated parties.		
11	350.02	The administrator or designee did not complete an investigation & written report for all incident within 30 days.		

Response Required Date	Signature of Facility Representative	Date Signed
12/2/07	Melissa Lichti	11/2/07

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II

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Wedgewood Terrace	3114 Vineyard Ave	208-743-3268
Administrator	**City**	**ZIP Code**
Melissa Licht	Lewiston	83501
Survey Team Leader	**Survey Type**	**Survey Date**
Debbie Shelley	Standard	11/2/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
12	550.03.a.iii -	The facility did not ensure the residents right to a safe and sanitary living environment.		
13	625.01	Staff records did not contain evidence of 16 hours of orientation.		
14	711.11	Facility staff did not document reasons medications were refused, not given or taken.		

Response Required Date	Signature of Facility Representative	Date Signed
12/3/07	Melissa Licht	11/2/07